DECLARATION OF KATHERINE FARRIS, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Katherine Farris, M.D., declare as follows:

1. I am a physician licensed to practice medicine in North Carolina, South Carolina, West Virginia, and Virginia. I am board-certified by the American Board of Family Physicians in family medicine.

2. Since July 2013, I have been Planned Parenthood South Atlantic's (PPSAT's) Interim Affiliate Medical Director, then Affiliate Medical Director, then Chief Medical Officer. As Chief Medical Officer, I am responsible for ensuring the high quality of the medical care that we provide to patients. In this position, I provide oversight, supervision, and leadership on all medical services we provide, including abortion. As part of my role, I collaborate with other members of PPSAT senior management to develop policies and procedures to ensure that the medical services we provide follow evidence-based guidelines and comply with all relevant laws. I also provide direct medical services for PPSAT.

3. I provide a range of family planning and reproductive health care to patients, including (among other things) both medication and procedural abortion, as well as miscarriage care, referrals for ectopic pregnancy care, contraception, and advanced gynecological care—such as complicated Intrauterine Device (IUD) and Nexplanon removals (Nexplanon is a birth control implant placed under the skin in the upper arm)—at PPSAT's North Carolina health centers in Winston-Salem, Charlotte, and Asheville (and periodically in Fayetteville, Wilmington, and Chapel Hill), as well as in the other states in which I am licensed. I have been employed by PPSAT since 2009 in various capacities as a medical doctor.

4. I earned my medical degree from the Northwestern University Medical School in 2000 and completed my residency at Valley Medical Center Family Practice, where I was Chief Resident in my last year. I am often called upon to present at educational institutions as an expert in abortion care and provider advocacy.

5. The facts I state here and the opinions I offer are based on my education, my years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, my review of PPSAT business records, information obtained through the course of my duties at PPSAT, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

6. A copy of my *curriculum vitae* is attached as **Exhibit A**.

I. SUMMARY OF OPINIONS

7. I submit this Declaration in support of PPSAT's motion for a temporary restraining order and preliminary injunction against the new North Carolina Session Law 2023-14 ("S.B. 20") which as of July 1, 2023, will bar PPSAT from providing abortion care to survivors of sexual assault and incest after the twelfth week of pregnancy and through the twentieth week of pregnancy and seems to prevent us from providing early medication abortions to patients who have a very early pregnancy that is not yet visible by ultrasound (pregnancy of unknown location).

8. In particular, while that law states that abortion is lawful "[a]fter the twelfth week and through the twentieth week of a woman's pregnancy, when the procedure is performed by a qualified physician in a suitable facility in accordance with G.S. 90-21.82A when the woman's pregnancy is a result of rape or incest," Section 90-21.82A says that "[a]fter the twelfth week of pregnancy, a physician licensed to practice medicine under this Chapter may not perform a

surgical abortion as permitted under North Carolina law in any facility other than a hospital." S.B. 20 § 90-21.81B(3); *Id.* § 90-21.82A(c).

9. This prohibition is contrary to the standard of care, under which abortions are routinely performed in outpatient settings through twenty weeks; is illogical as a matter of patient health and safety because even once S.B. 20 takes effect, outpatient health centers can still provide this same care in the case of miscarriage; and will only serve to harm patients who have experienced sexual assault.

10. And although the law states it is lawful to provide an abortion "during the first 12 weeks of a woman's pregnancy when a medical abortion is procured," *Id.* § 90-21.81B(2), it also requires the physician to "[d]ocument in the woman's medical chart the probable gestation age and intrauterine location of the pregnancy." *Id.* § 90-21.83B(a)(7). This too will harm patients as not only is it safe to provide medication abortion to patients with positive pregnancy tests but whose pregnancies are too early to document an intrauterine location, but this early abortion care is all the more important given the twelve-week ban.

11. Abortion is extremely safe, but the medical risks associated with abortion increase with gestational age. Denying care to patients whose pregnancies cannot yet be seen on an ultrasound may force them to wait until later in their pregnancies before they can get the care they have chosen. This would expose them to unnecessary medical risk.

II. PPSAT AND ITS SERVICES

12. PPSAT is a non-profit corporation organized under the laws of North Carolina. PPSAT offers a wide range of affordable and reliable reproductive and sexual health care services in our 14 locations across North Carolina, South Carolina, Virginia, and West Virginia. PPSAT operates nine health centers throughout North Carolina, located in Asheville, Chapel Hill,

Charlotte, Durham, Fayetteville, Greensboro, Raleigh, Wilmington, and Winston-Salem. Altogether, these health centers provide a full range of family-planning services, including well-person preventive care visits; breast exams; Pap tests; sexually transmitted infection (STI) testing; a wide range of U.S. Food and Drug Administration (FDA)-approved contraception methods, including highly effective, long-acting reversible contraceptives; pregnancy testing; risk assessments to screen for high-risk issues; referral services for pregnant women; urinary tract infection treatment; cervical cancer and testicular cancer screening; fertility awareness services; and vasectomies. PPSAT provides care to approximately 38,000 patients at its health centers in North Carolina each year.

13. PPSAT provides abortions at six health centers licensed under North Carolina law as abortion clinics located in Asheville, Chapel Hill, Charlotte, Fayetteville, Wilmington, and Winston-Salem. At these health centers, we provide both medication abortion through 77 days gestation as measured from the first day of the last menstrual period (LMP) and procedural abortion up to 13.6 to 19.6 weeks LMP depending on staffing. PPSAT has been providing procedural abortions past 12 weeks LMP for more than fifteen years in North Carolina. During the past five years, only 0.69 percent of PPSAT's North Carolina patients who have received a procedural abortion have sought follow up hospital-based care. Following S.B. 20 taking effect on July 1, PPSAT will be forced to stop providing abortions after the twelfth week pregnancy, including in cases of rape and incest.

III. ABORTION IS COMMON, SAFE, AND CRITICAL HEALTH CARE

A. Abortion Methods Performed in Outpatient Settings.

14. All methods of abortion provided at PPSAT—medication abortion, procedural abortion using aspiration and procedural abortion by dilation and evacuation (D&E)—are simple,

straightforward medical treatments that typically take no more than 10 to 15 minutes, have an extremely low complication rate, are almost always provided in outpatient, office-based settings, and, unlike some other office-based procedures such as vasectomies, involve no incisions.

15. Although aspiration abortion and D&E are both sometimes referred to as "surgical" abortion, they are not what is commonly understood to be surgery. Both aspiration abortion and D&E are done through the natural opening of the vagina and cervix and therefore involve no incisions. Both can be, and almost always are, performed in outpatient clinics like PPSAT by clinicians adhering to widely-accepted medical standards of care. In 2022, 38% of the abortions provided at PPSAT were procedural abortions.

i. Medication Abortion

16. Medication abortion uses medication to cause uterine contractions to empty the uterus. It requires no anesthesia or sedation. PPSAT provides the most common form of medication abortion from the time a patient receives a positive pregnancy test through 11 weeks, or 77 days, LMP.

17. In a typical medication abortion, the patient takes a combination of two prescription drugs—mifepristone (also known as RU-486 or by its trade name, Mifeprex) and misoprostol (also known as a prostaglandin analogue or by its trade name, Cytotec)—a day or two apart. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol causes the cervix to open and the uterus to contract and empty. These same medications are offered as a treatment option to patients who have a miscarriage with retained tissue. Indeed, the process of medication abortion very closely approximates the process of miscarriage.

18. Mifepristone and misoprostol are safe—substantially safer than Tylenol and Viagra, for example.[1] The FDA approved mifepristone, by its brand name Mifeprex, in 2000. Decades of experience with medication abortion since then have resoundingly confirmed its safety and efficacy. Indeed, earlier this year, the FDA modified its dispensing requirements for mifepristone to reflect the ever-growing body of evidence demonstrating the safety and effectiveness of medication abortion.[2] While the FDA-approved labeling for mifepristone reflects its usage through 70 days LMP, there is significant evidence that supports its use through 77 days LMP, as is provided at PPSAT.[3]

ii. Aspiration Abortion

19. Aspiration abortion (also known as suction curettage or dilation & curettage) entails using suction to empty the uterus. It is a straightforward procedure performed in the first and early second trimester. PPSAT provides aspiration abortion up to 14 weeks LMP. A small plastic tube, called a cannula, is passed through the cervical canal. The cannula is attached to a syringe or electrical pump that creates gentle suction to empty the uterus.

20. Prior to starting the suction procedure, the provider dilates the cervix as needed to allow the cannula to enter the uterus. An analgesic such as ibuprofen, an anti-anxiety medication

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[1] *See Analysis of Medication Abortion Risk and the FDA report, "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018"*, Advancing New Standards in Reproductive Health (April 2019), https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf.

[2] *See Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA, https://www.fda.gov/drugs/postmarket-drug-safety-information- patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last reviewed Mar. 23, 2023).

[3] *See, e.g.*, Ilana G. Dzuba et al., *A Repeat Dose of Misoprostol 800 mcg Following Mifepristone for Outpatient Medical Abortion at 64–70 and 71–77 Days of Gestation: A Retrospective Chart Review*, 102 Contraception 104 (2020); Ilana G. Dzuba et al., *A Non-Inferiority Study of Outpatient Mifepristone-Misoprostol Medical Abortion at 64–70 days and 71–77 Days of Gestation*, 101 Contraception 302 (2020).

such as Ativan or Valium, a local anesthetic such as Lidocaine, and/or moderate sedation may be used during or prior to the procedure.

21. The entire procedure, including administration of local anesthesia, dilating the cervix, and aspirating the uterine contents takes 3 to 5 minutes. It involves no incision, cutting, or suturing.

22. Procedural abortions employ the same procedure and instruments used to treat a miscarriage after embryonic or fetal demise has occurred naturally, and for pregnancies of the same gestational age there is no difference in the risk of complications between a procedure to manage early miscarriage and aspiration abortion. PPSAT currently also provides miscarriage management.

iii. D&E Abortion

23. Dilation and evacuation, or D&E, uses a combination of gentle suction and additional instruments, including specialized forceps, to evacuate the pregnancy contents from the uterus. While we generally refer to procedures starting at 14 weeks LMP as “D&E’s”, instruments are routinely used in addition to suction starting around 15 weeks LMP, depending on the provider’s individual practice and the patient’s individual medical characteristics.

24. Prior to the D&E procedure, the provider dilates the patient’s cervix to ease and advance cervical dilation, which assures clinical safety. This may be done through medications such as misoprostol, which softens the cervix, and/or the placement of osmotic dilators in the cervix, which gradually swells as it absorbs moisture, causing the cervix to dilate. The provider may also use mechanical dilators or a combination of these techniques. The provider then empties the uterus using instruments or a combination of suction and instruments. Minimal to moderate sedation may be used.

25. In the early part of the second trimester, physicians may perform the cervical preparation and evacuation on the same day. Later in the second trimester, the physician may start the dilation process one day before the evacuation. In most cases, we begin the dilation process for patients from 16 to 20 weeks LMP through the placement of osmotic dilators the day before evacuation.

26. The entire evacuation procedure typically takes 10 to 15 minutes. Like aspiration abortion, D&E does not involve any incision, cutting, or suturing. And like aspiration, the same procedure can be and is used in cases of miscarriage.

B. Abortion is one of the safest procedures in medicine.

27. S.B. 20 does not improve patient health and safety. Abortion is one of the safest procedures in contemporary medical practice and is safely and routinely provided in outpatient settings in countries around the world. Leading medical authorities agree that abortion is one of the safest procedures in medical practice,[4] "stand[ing] in contrast to the extensive regulatory requirements that state laws impose on the provision of abortion services."[5]

28. In fact, major complications, defined as those requiring hospital admission, surgery, or blood transfusion, occur in just 0.23 percent of abortions performed in outpatient, office-based settings.[6]

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[4] Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 77 (2018), available at http://nap.edu/24950 ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.").

[5] *Id.*

[6] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 177 (2015); *see also* Ushma D. Upadhyay et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16 BMC Med. 1, 1 (2018).

29. Abortion compares favorably, with a markedly lower complication rate, to other procedures routinely performed in outpatient, office-based settings, including:

- vasectomies, a form of male birth control that involves transecting and cauterizing the vas deferens, the tubes that carry sperm, resulting in complications two percent of the time while major complications requiring hospitalization occur in 0.2–0.8 percent of cases;[7]
- colonoscopies, an exam used to look for changes in the large intestine (colon) and rectum, such as swollen, irritated tissues, polyps or cancer, with a complication rate of 1.6 percent;[8]
- wisdom teeth extraction, a surgical procedure to remove one or more of the four permanent teeth located at the back corners of the mouth, with a complication rate of 6.9 percent;[9] and
- tonsillectomies, surgical removal of the tonsils, with a complication rate of 7.9 percent.[10]

30. Abortion is significantly safer than the alternative of carrying a pregnancy to term and giving birth.[11] The United States has the highest maternal mortality rate among high-income countries (more than four times the rate of others in that group). Most concerningly, it is getting

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[7] Christopher E. Adams & Moshe Wald, *Risks and Complications of Vasectomy*, 36 Urologic Clinics N. Am. 331 (2009).

[8] Isuru Ranasinghe et al., *Differences in Colonoscopy Quality Among Facilities: Development of a Post-Colonoscopy Risk-Standardized Rate of Unplanned Hospital Visits*, 150 Gastroenterology 103, 103 (2016).

[9] Francois Blondeau & Nach G. Daniel, *Extraction of Impacted Mandibular Third Molars: Postoperative Complications and their Risk Factors*, 73 J. Canadian Dental Ass'n 325 (2007).

[10] Jack L. Paradise et al., *Tonsillectomy and Adenotonsillectomy for Recurrent Throat Infection in Moderately Affected Children*, 110 Pediatrics 7 (2002).

[11] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215 (2012).

worse. In 2021, the maternal mortality rate increased 40 percent from the previous year.[12] That year alone, 1,205 pregnant women died of pregnancy-related causes in the United States.[13] The Centers for Disease Control and Prevention (CDC) measure maternal mortality rates as the number of maternal deaths per 100,000 live births.[14] In 2021, the maternal mortality rate was 32.9 deaths per 100,000 live births.[15]

31. In contrast, the CDC reported 0.43 deaths per 100,000 legal abortions from 2013 to 2019.[16] While the U.S. maternal mortality rate has significantly increased, there is no evidence that has occurred for abortion care, making legal abortion approximately 12 to 14 times safer than live birth.[17]

C. Abortions are safely performed in outpatient, office-based settings.

32. There is no medical reason to require abortion to take place in hospitals and not abortion clinics. In North Carolina, as is done throughout the country, legal abortions are safely and routinely performed in doctors' offices and outpatient health center settings. Procedural abortions are almost always provided in an outpatient setting; nationwide, only 3% of abortions annually are performed in hospitals.[18] In addition, abortions at outpatient clinics are most often more affordable, easier to navigate, and require considerably less time for patients.

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[12] Donna L. Hoyert, Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Stats., *Maternal Mortality Rates in the United States, 2021*, at 1 (2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] Katherine Kortsmit et al., *Abortion Surveillance—United States, 2020*, 71 Morbidity & Mortality Weekly Rep. 1, 6 (2022), available at https://www.cdc.gov/mmwr/volumes/71/ss/pdfs/ss7110a1-H.pdf.

[17] Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 4, at 75; Raymond & Grimes, *supra* note 11, at 215.

[18] Rachel K. Jones et al., *Abortion incidence and service availability in the United States, 2020*, 54 Perspect. Sex Reprod. Health 128, 134 (2022).

33. According to the National Academies of Sciences, Engineering, and Medicine, "most abortions can be provided safely in office-based settings," and a hospital setting is not clinically necessary.[19] Similarly, major medical associations, including the American College of Obstetricians and Gynecologists (ACOG) and the American Public Health Association, reject the notion that abortions should be performed in hospitals.[20]

34. The technique for a procedural abortion is clinically identical when performed in a hospital or outpatient setting, and there is no scientific evidence indicating that abortions performed in a hospital are safer than those performed in an appropriate outpatient, office-based setting.[21] To the contrary, as is true for nearly every medical procedure, fewer complications are seen in settings that perform higher volumes of the same procedure, making abortion clinics like PPSAT safer than hospitals for most abortion patients.[22] In fact, at least one study demonstrated that second-trimester terminations of pregnancy by D&E in well-selected patients in a dedicated outpatient facility can be safer and less expensive than hospital-based D&E or induction of labor.[23] It is unreasonable, and a waste of hospital resources, to require a procedure to be performed in a hospital when there is no medical indication or benefit. As with any other medical procedure, clinic- or office-based care should be provided in a different setting when a patient's individual medical circumstances dictate such a need.

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[19] *Id.* at 10, 77.

[20] ACOG, *Guidelines for Women's Health Care: A Resource Manual* (4th ed. 2014).

[21] Sarah C. M. Roberts et al., *Association of Facility Type with Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319 JAMA 2497 (2018).

[22] Steve Sternberg & Geoff Dougherty, *Risks are High at Low-Volume Hospitals*, U.S. News & World Report, May 18, 2015, 12:01 A.M., https://www.usnews.com/news/articles/2015/05/18/risks-are-high-at-low-volume-hospitals.

[23] David K.Turok et al, *Second trimester termination of pregnancy: a review by site and procedure type*, 77 Contraception 155, 155 (2008).

35. PPSAT physicians have low abortion complication rates and superb safety records. Because PPSAT specializes in providing patient-centered, holistic sexual and reproductive health care, PPSAT patients benefit from receiving care from highly experienced and specialized providers and staff. This is particularly important for the patient population we are talking about here—survivors of sexual assault who may be more comfortable with a provider like Planned Parenthood than having to navigate a hospital, especially one to which they need to travel outside of their community.

36. The hallmark features that differentiate hospitals from abortion clinics include system operations requirements, staffing requirements, and building construction requirements.[24] Not only are these features irrelevant and unnecessary in the context of abortion care, they also provide no medical benefit.

37. Unlike invasive surgical procedures, aspiration abortion, which uses gentle suction to empty the uterus, and D&E, which uses a combination of gentle suction and instruments to empty the uterus, do not involve incisions of any kind. In North Carolina, procedures with risks similar to the risks associated with abortion—including inserting or removing and IUD; endometrial biopsy; colposcopy; hysteroscopy (scoping of the cervix and uterus); Loop Electrosurgical Excision Procedure (LEEP) (removing pre-cancerous cells from the cervix); and miscarriage management, which, from a clinical perspective, involves the same procedures as aspiration abortion—are routinely performed in outpatient clinics and physicians' offices rather than in hospitals. And the procedures noted above with higher complication rates than abortion (like colonoscopies and wisdom teeth extraction) are routinely, and without controversy, performed in outpatient, office-based settings throughout North Carolina.

[24] *Compare* 10A N.C. Admin. Code 13B.3201 (hospital requirements) *with* 10A N.C. Admin. Code 14E .0100 *et. seq.* (abortion facility requirements).

38. Even in the rare event abortion complications arise during a procedural abortion, management can nearly always be safely and appropriately administered in an outpatient, office setting.[25] For example, most cases of hemorrhage (the technical term for bleeding) are managed in the clinic setting with uterotonic medications, like misoprostol, that cause uterine contractions and reduce bleeding and with uterine massage.[26] Most cases of cervical laceration are managed in the clinic setting either with Monsel's Solution or suture.[27] Cases of incomplete abortion are generally managed through repeat aspiration or medication, and, at any rate, arise after completion of the procedure and, even if the abortion took place in a hospital, would occur only after the patient leaves the hospital.

39. In the rare event that a patient experiences infection as a result of a procedural abortion, the infection would typically not develop until days after the procedure. At that time, a patient diagnosed with infection would receive treatment with oral antibiotics on an outpatient basis; i.e., they would take the antibiotics at home or a place of their choosing. Oral antibiotics almost always resolve infection without any long-term or permanent injury to the patient. The use of intravenous or intramuscular antibiotics to treat infection arising from procedural abortion is rare, and both can be provided in an outpatient setting.

40. As discussed above, major abortion complications occur in fewer than one-quarter of one percent (0.23 percent) of abortions.[28] In the exceedingly rare event that a higher level of care is needed to manage complications, patients are safely stabilized and transferred to a hospital.

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[25] Roberts et al., *supra* note 21; Nat'l Acads. of Scis., Eng'g, & Med., *supra* note 4.

[26] Jennifer Kearns & Jody Steinhauer, *Management of postabortion hemorrhage*, 87 Contraception 331, 333 (2013).

[27] *Id.*

[28] Upadhyay et al., *Incidence of Emergency Department Visits*, *supra* note 6, at 175.

In the last five years at PPSAT, 0.22 percent of procedural abortion patients have been transferred to a hospital.

D. Medication abortion is safe to provide in early pregnancies before the intrauterine location of the pregnancy can be determined.

41. Some patients present for abortions at very early gestational ages. At early gestational stages, though the patient has a positive pregnancy test, it may be too soon to see an intrauterine gestational sac via ultrasound. PPSAT follows an established protocol for safely administering medication abortion in early pregnancies before the location of the pregnancy can be visualized and determined. Such early administration of medication abortion has been shown to be safe and effective in terminating the pregnancy, and there is no medical reason to deny patients this care.[29]

42. Banning medication abortion, but not procedural abortion, for pregnancies of unknown location is arbitrary and unnecessary. It would force patients either to undergo a procedural abortion, when they feel that a medication abortion is best for them, or to delay their abortion until the pregnancy can be seen within the uterus.

IV. IMPACT ON PPSAT PATIENTS

A. Impact on Rape and Incest Survivors

43. Thousands of North Carolinians suffer sexual abuse each year, and they desperately need access to abortion. Because of the non-consensual nature of rape and incest, these survivors are at heightened risk of unwanted pregnancy. And many of them are also the most desperate to terminate a pregnancy because of the traumatic circumstances in which that pregnancy is occurring. The physical aspects of pregnancy, including the sense of losing control of one's body,

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[29] *See, e.g.*, Alisa B. Goldberg et al., *Mifepristone and Misoprostol for Undesired Pregnancy of Unknown Location*, 139(5) Obstet Gynecol. 771 (2022) (Rate of successful medication abortion was 85.4% in pregnancies where location was unknown).

can be particularly traumatic to patients who are otherwise not in control of their bodies or their lives. For these survivors, pregnancy can trigger flashbacks, dissociative episodes, and other symptoms of re-traumatization.

44. Additionally, many abuse or sexual assault survivors have health reasons for seeking an abortion. There is a strong association between intimate partner violence, incest, and mental health problems, and women may feel they are not healthy enough to parent a child. Or they may need psychiatric medications that are inadvisable during pregnancy.

45. It is already hard for those who have experienced intimate partner violence to access abortion care in many instances. In particular, it can be difficult if not impossible for victims to escape their partner's physical, emotional, and financial control long enough to access an abortion, as they must often do so secretly. In cases where they have been physically isolated from the community, they may not be able to leave their homes to seek routine medical care in the hours or days directly following the assault, let alone later have access to transportation and financial means to access other follow-up services or abortion providers.

46. Even when survivors are able to access reproductive care, the process of finding a way to do so can delay them substantially, making them more likely to need abortion after twelve weeks of pregnancy. These survivors may also be unsure of the gestational age of their pregnancies, so they may present to outpatient clinics for the state-mandated informed consent visit, but find they are beyond their first 12 weeks of pregnancy. Under S.B. 20, those patients would have to be referred to a hospital provider despite the clinic being able to safely provide the care, forcing the patient who has already experienced trauma to present to and share their story with another provider.

47. And, if the hospital-based provider will not accept the state-mandated informed consent visit from the clinic (or if they cannot due to the clinic not having been able to provide the name of the physician or the insurance information required by Section 90-21.83C, a provision also challenged in this case), it would force the patient to receive that information again and to restart the 72 hour waiting period.

48. Even if a rape or incest survivor already knew they were beyond their twelfth week of pregnancy, they will have fewer options for care because there are not likely to be many hospitals in the state that will provide abortions.

49. In addition, abortions at hospitals are generally much more expensive than they would be at PPSAT. Patients who are able to get an appointment at a hospital may also face lengthy wait times, added stress, complicated paperwork and other logistical requirements, loss of confidentiality, and possibly increased medical risk from providers who may provide abortion care infrequently. Particularly when general anesthesia is used, as is done in many hospitals, the total appointment time, post-procedure recovery time, staffing and facility requirements, costs, and procedure risks increase.

50. Though hugely variable, abortions in hospitals can cost thousands of dollars. Given that only one in three Americans can comfortably cover a $400 emergency expense, the financial burden of an abortion at a hospital will be insurmountable for many would-be patients.[30] At PPSAT, patients can obtain an abortion, as at other outpatient abortion clinics, for a fraction of the cost charged by hospitals. At PPSAT, the cost of an abortion varies based on gestational age from $620 to $1720.

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[30] Bd. of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2021*, at 36 (May 2022), available at https://www.federalreserve.gov/publications /files/2021-report-economic-well-being-us-households-202205.pdf.

51. Due to cost alone, if a patient could find a hospital willing to provide their abortion, hospital treatment would not be feasible for many of PPSAT's patients. Arranging for transportation, childcare, and taking time off work to come to PPSAT is challenging enough. Studies demonstrate increased barriers to access increase the likelihood a patient will not receive care.[31] A majority of patients seeking abortion are already parents. Many have multiple jobs or jobs with inflexible or unpredictable schedules with no paid sick leave. Some are compromised by physical and/or mental health conditions or struggle with a substance abuse disorder.

52. Studies also demonstrate that increased barriers to access increase the likelihood a patient will not receive care.[32] In addition, delay of any kind is particularly concerning because, while abortion is safe, its risks increase with gestational age, as does the invasiveness of the procedure and the need for deeper levels of sedation.

53. For all of these reasons, limiting access to care for survivors of rape and sexual assault will cause great harm even to those who are able to access care in a North Carolina hospital. But for many others, S.B. 20 will put that care out of reach and the only remaining options will be to travel out of state to get an abortion or attempt to manage their abortion outside of the medical system. In practice, for many, this will mean that they will be forced to remain pregnant and ultimately give birth against their will.

B. Impact on Access To Early Abortion Care

54. If PPSAT is unable to offer medication abortion to patients who present with a positive pregnancy test but a pregnancy of unknown location, this too will be devastating for

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[31] *See e.g.*, Benjamin P. Brown et al., *Association of Highly Restrictive State Abortion Policies With Abortion Rates, 2000-2014*, 3 JAMA Network Open 1, 1 (2020) ("A highly restrictive policy climate, when compared with a less restrictive one, was associated with a … 17% decrease [in] the median abortion rate….").

[32] *Id.*

patients. This is especially so because S.B. 20 already imposes a requirement that patients make two trips to a health center to access care (in addition to the follow up appointment that is required to be scheduled for medication abortion patients). If we cannot go forward providing medication abortion to these patients, they may need to make another, wholly medically unnecessary trip which will further delay their access to care. Early access to care is always preferable, but this is even more so because S.B. 20 bans almost all abortions after 12 weeks.

55. In these ways (and many others), S.B. 20 is not only harmful to our patients, but also impairs PPSAT and its physicians' ability to practice their profession and to satisfy their personal and professional missions and obligations of providing high-quality, evidence-based comprehensive reproductive health care to people in North Carolina.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: June 21, 2023

Katherine Farris, M.D.

EXHIBIT A

Katherine A. Farris, M.D.

Employment

Planned Parenthood South Atlantic Winston-Salem/Raleigh, NC

Chief Medical Officer: April 2020 – present

Duties of Affiliate Medical Director with increased focus on strategic planning, oversight of new service lines including Primary Care, and increased advocacy work in support of PPSAT mission.

Affiliate Medical Director: December 2014 – April 2020

Clinical, policy, and administrative oversight for 14 health centers located throughout NC, SC, VA, and WV.

Laboratory Director: December 2014 – present

Oversight of non-waived laboratories WS, NC; AVL, NC; WILM, NC; CLT, NC; waived laboratory VIE, WV

Interim Abortion Facility Administrator: December 2019 – March 2020

Acting Vice President of Patient Services: March – June 2016; May – August 2017

Interim Affiliate Medical Director: July 2013 – December 2014

Reproductive Health Care: September 2009-present

Provision of comprehensive family planning services to women of all ages as well as STI counseling, testing and treatment to men and women.

PPFA Succession Planning Task Force, Member: April 2017 – March 2021

Task force was charged with addressing some of the systemic challenges of abortion provider training and recruitment at Planned Parenthood affiliates.

Medical Directors Council (MeDC), Mentor: 2015 – present

Serve as mentor to new Medical Directors/Chief Medical Officers at other PPFA Affiliates.

BetterHealth IT Board of Directors,

Member: September 2020 – present

Chair, Compliance Committee: January 2023 – present

Board member for the organization responsible for providing revenue cycle services and supporting and rolling out Epic electronic medical records system across PPFA affiliates.

(Prior to merger and name change January 2015, organization was named Planned Parenthood Health Systems, Inc.)

Heywood Medical Group/Henry Heywood Hospital Westminster/Gardner, MA

Family Practice/Obstetrics: August 2003 – May 2007

Meetinghouse Family Practice; 16 Wyman Rd.; Westminster, MA 01473

Provision of full-spectrum family medicine including comprehensive family planning and reproductive health care.

Planned Parenthood League of Massachusetts Boston/Worcester, MA

Reproductive Health Care: August 2003 – May 2007

Provision of comprehensive family planning services to women of all ages.

Education

Valley Medical Center Family Practice Residency Renton, WA

Chief Resident: 2002-2003

Residency: 2001-2003

Internship: 2000-2001

Northwestern University Medical School Chicago, IL

Degree: MD, 1995-2000

Northwestern University College of Arts and Sciences Evanston, IL

Degree: BA, 1991-1995

Major: Molecular and Cellular Biology Minor: Religion Studies

Certifications/Special Training

Physician for Reproductive Health, Leadership Training Academy Fellow 2018-2019
Basic Life Support/AED, Provider: renewed 10/2021
Title X Family Planning Program Training, Provider: 2015
CLIA Laboratory Director Training, Training for non-waived laboratory director: 2013
Single-rod Hormonal Implant Insertion Training, Provider: 2011, Certificate #30001820273

Professional Organizations / Positions

American Academy of Family Physicians (AAFP): 1995-present
North Carolina Academy of Family Physicians: 2007-present
National Abortion Federation (NAF): 2003-2005, 2018-present
Physicians for Reproductive Health: 2018-present
American College of Obstetricians and Gynecologists: 2020-present
Massachusetts Academy of Family Physicians: 2003-2007
Washington Academy of Family Physicians (WAFP): 2000-2003
American Medical Women's Association (AMWA): 1995-2000
Northwestern University Chapter President: 1997-1998
Vice-President: 1996-1997

Licenses

NC Physician License, active: 143375-2009
WV Physician License, active: 26126
VA Physician License, active: 0101265486
SC Physician License, active: MMD.84073 MD
American Board of Family Physicians, Board Diplomate

Honors/Awards

Sylvia Clark Award for Creativity in Clinical Services – Recipient 2023
Honors a clinical services provider team from a Planned Parenthood affiliate who, through their creativity in clinical services, have demonstrated special commitment and ingenuity in applying the PPFA mission to ensure access to reproductive and sexual health care for all.

Press Ganey Patient Experience Top Performing Provider 2020
Ranked in the top 10% of providers across the country for providing the highest level of patient experience.

2002 Roy Virak Memorial Family Practice Resident Scholarship Recipient
Awarded by the Washington Academy of Family Practice on the basis of academic achievement, excellence in patient care, and strong service to the community.